BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
RICHARD DAVID LE, M.D.	)	Case No. 800-2017-031057
Physician's and Surgeon's Certificate No. A88276	)	
Respondent	)	

DECISION

The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on July 25, 2019.

IT IS SO ORDERED: June 25, 2019.

MEDICAL BOARD OF CALIFORNIA

Ronald Lewis, M.D., Chair
Panel A

XAVIER BECERRA
Attorney General of California
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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: RICHARD DAVID LE, M.D. 1211 West La Palma Avenue, Suite 207 Anaheim, CA 92801 Physician's and Surgeon's Certificate No. A 88276, Respondent.	Case No. 800-2017-031057 OAH No. 2018120944 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Kimberly Kirchmeyer ("Complainant") is the Executive Director of the Medical Board of California ("Board"). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Rebecca L. Smith, Deputy Attorney General.

2. Respondent Richard David Le, M.D. ("Respondent") is represented in this proceeding by attorneys Dennis K. Ames and Pogey Henderson, whose address is 2677 North Main Street, Suite 901, Santa Ana, CA 92705-6632.

3. On or about July 23, 2004, the Board issued Physician's and Surgeon's Certificate No. A 88276 to Respondent. That license was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2017-031057, and will expire on January 31, 2020, unless renewed.

JURISDICTION

4. Accusation No. 800-2017-031057 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on November 27, 2018. Respondent filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2017-031057 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2017-031057. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

8. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

9. Respondent does not contest that, at an administrative hearing, Complainant could establish a prima facie case with respect to the charges and allegations contained in Accusation No. 800-2017-031057 and that he has thereby subjected his license to disciplinary action.

10. Respondent agrees that if he ever petitions for early termination or modification of probation, or if the Board ever petitions for revocation of probation, all of the charges and allegations contained in Accusation No. 800-2017-031057 shall be deemed true, correct and fully admitted by Respondent for purposes of that proceeding or any other licensing proceeding involving Respondent in the State of California.

11. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

CONTINGENCY

12. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

13. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

14. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

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DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 88276 issued to Respondent Richard David Le, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for three (3) years on the following terms and conditions.

1. EDUCATION COURSE. Within sixty (60) calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than forty (40) hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education ("CME") requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for sixty-five (65) hours of CME of which forty (40) hours were in satisfaction of this condition.

2. PRESCRIBING PRACTICES COURSE. Within sixty (60) calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education ("CME") requirements for renewal of licensure.

A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than fifteen (15) calendar days after successfully completing the course, or not later than fifteen (15) calendar days after the effective date of the Decision, whichever is later.

3. MEDICAL RECORD KEEPING COURSE. Within sixty (60) calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education ("CME") requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than fifteen (15) calendar days after successfully completing the course, or not later than fifteen (15) calendar days after the effective date of the Decision, whichever is later.

4. CLINICAL COMPETENCE ASSESSMENT PROGRAM. Within sixty (60) calendar days of the effective date of this Decision, Respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than six (6) months after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The program shall consist of a comprehensive assessment of Respondent's physical and mental health and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to

Respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. The program shall require Respondent's on-site participation for a minimum of three (3) and no more than five (5) days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether Respondent has demonstrated the ability to practice safely and independently. Based on Respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with the program's recommendations.

Determination as to whether Respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction.

If Respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed. If Respondent did not successfully complete the clinical competence assessment program, Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

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5. MONITORING - PRACTICE. Within thirty (30) calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties ("ABMS") certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision and Accusation, and a proposed monitoring plan. Within fifteen (15) calendar days of receipt of the Decision, Accusation, and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision and Accusation, fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within sixty (60) calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within sixty (60) calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices

are within the standards of practice of medicine, and whether Respondent is practicing medicine safely. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within ten (10) calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within five (5) calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within fifteen (15) calendar days. If Respondent fails to obtain approval of a replacement monitor within sixty (60) calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, Respondent may participate in a professional enhancement program approved in advance by the Board or its designee that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

6. SOLO PRACTICE PROHIBITION. Respondent is prohibited from engaging in the solo practice of medicine. Prohibited solo practice includes, but is not limited to, a practice where: 1) Respondent merely shares office space with another physician but is not affiliated for purposes of providing patient care, or 2) Respondent is the sole physician practitioner at that location.

If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within sixty (60) calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall not resume practice until an appropriate practice setting is established.

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If, during the course of the probation, Respondent's practice setting changes and Respondent is no longer practicing in a setting in compliance with this Decision, Respondent shall notify the Board or its designee within five (5) calendar days of the practice setting change. If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within sixty (60) calendar days of the practice setting change, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall not resume practice until an appropriate practice setting is established.

7. NOTIFICATION. Within seven (7) days of the effective date of this Decision, Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within fifteen (15) calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

8. SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES. During probation, Respondent is prohibited from supervising physician assistants and advanced practice nurses.

9. OBEY ALL LAWS. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

10. QUARTERLY DECLARATIONS. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than ten (10) calendar days after the end of the preceding quarter.

11. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Place of Practice

Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal

Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event Respondent should leave the State of California to reside or to practice ,Respondent shall notify the Board or its designee in writing thirty (30) calendar days prior to the dates of departure and return.

12. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

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13. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within fifteen (15) calendar days of any periods of non-practice lasting more than 30 calendar days and within fifteen (15) calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least forty (40) hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If Respondent resides in California and is considered to be in non-practice, Respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve Respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds eighteen (18) calendar months, Respondent shall successfully complete the Federation of State Medical Boards's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a Respondent residing outside of California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing.

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14. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than one-hundred twenty (120) calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

15. VIOLATION OF PROBATION. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

16. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within fifteen (15) calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

17. PROBATION MONITORING COSTS. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

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ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorneys, Dennis K. Ames and Pogey Henderson. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 6/3/19

RICHARD DAVID LE, M.D.
Respondent

I have read and fully discussed with Respondent Richard David Le, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 6/3/19

DENNIS K. AMES
POGEY HENDERSON
Attorneys for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

Dated: 6/3/19

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General

REBECCA L. SMITH
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2017-031057

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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: Richard David Le, M.D. 1211 West La Palma Avenue, Suite 207 Anaheim, California 92801 Physician's and Surgeon's Certificate No. A 88276, Respondent.	Case No. 800-2017-031057 **ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer ("Complainant") brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs ("Board").

2. On or about July 23, 2004, the Board issued Physician's and Surgeon's Certificate number A 88276 to Richard David Le, M.D. ("Respondent"). That license was in full force and effect at all times relevant to the charges brought herein and will expire on January 31, 2020, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board under the authority of the following provisions of the California Business and Professions Code ("Code") unless otherwise indicated.

4. Section 2004 of the Code states:

"The board shall have the responsibility for the following:

"(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

"(b) The administration and hearing of disciplinary actions.

"(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

"(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

"(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

"..."

5. Section 2227 of the Code states:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the board.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

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"(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

6. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

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7. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

FACTUAL ALLEGATIONS

8. Patient 1, a then 32-year-old male patient, presented to PIH Health Urgent Care Clinic ("urgent care") on Friday March 10, 2017 for an evaluation of an acute onset of shortness of breath and cough with a complaint that he cannot catch his breath.[1] He was seen by Physician Assistant A.D. The patient was noted to have a positive fever, no history of asthma, no chest pain and no palpitations. His past medical history was significant for poorly controlled type 2 diabetes, hypertension, hyperlipidemia, microalbuminuria, obesity and anemia. With respect to his vital signs, he was noted to have a temperature of 101 degrees Fahrenheit (°F), heart rate of 123, respirations of 40, blood pressure of 145/83 while sitting and oxygen saturation of 88% on room air.[2] He was placed on supplemental oxygen by face mask. His physical examination was unremarkable other than his pulmonary examination which revealed poor breath sounds and wheezing. Physician Assistant A.D.'s assessment was reactive airway disease with wheezing. Medications used to treat respiratory diseases and shortness of breath were administered. Thereafter, patient was sent to Whittier Hospital's emergency department by ambulance at approximately 11:43 a.m. secondary to acute respiratory distress.

9. Patient 1 arrived at Whittier Hospital on March 10, 2017 at approximately 12:07 p.m. He was evaluated in the emergency department by Dr. S.D., who noted that the patient continued to be dyspneic with wheezing. Physical examination revealed diffuse bilateral rhonchi, positive labored respirations and breath sounds equal bilaterally.

10. Laboratory and diagnostic testing was performed while the patient was in the emergency department. The patient had a high white blood count of 15.1 (reference range 4.5 to

[1] For privacy purposes, the patient in this Accusation is referred to as Patient 1.

[2] With respect to vital-sign reference ranges for an adult: normal body temperature is 96°F to 100.8°F; normal resting hearing rate is from 60 to 100 beats per minute; normal respiration rate is 12 to 20 breaths per minute; normal blood pressure is between 120/80 to 140/90; and normal oxygen saturation on room air is 94 to 99%.

11), low red blood count of 3.83 (reference range 4.30 to 5.90), low hemoglobin of 11.2 (reference range 13.9 to 16.3) and low hematocrit of 34.2 (reference range 39 to 55). He had a high HG A1C at 7.9% (reference range 4.0-5.6), high glucose of 283 (reference range 74 to 106), high creatinine of 1.66 (reference range 0.60 to 1.30) and high lactic acid level of 6.4 (reference range 0.4 to 2.0). His C-Reactive protein was 32.2 (reference range 0.00 to 0.99) and his troponin was 0.10 (reference range 0.00 to 0.40). Arterial blood gases showed a pH of 7.43 (reference range 7.35 to 7.45), a low PCO2 of 30.4 (reference range 35.0 to 45.0) and a PO2 of 55 (reference range of 50-100). Blood cultures, pneumococcal antigen in urine, Influenza A and B and Legionella swabs were all negative. Ultrasound of the legs did not reveal a deep venous thrombosis. An electrocardiography (EKG) performed at 12:17 showed a sinus tachycardia, right axis deviation and nonspecific T-wave abnormalities. At 1:25 p.m., the patient's B-type natriuretic peptide (BNP) was elevated at 594 (normal range is 3-100).[3] A chest x-ray completed at 3:04 p.m. showed bilateral infiltrates. The patient was given 30 ml/kg of normal saline, amounting to 3,400 cc at 3:00 p.m. and placed on intravenous antibiotics, Rocephin and Zithromax.

11. Dr. S.D.'s diagnoses were (1) bilateral pneumonia, (2) poorly controlled diabetes; (3) hypoxia and (4) sepsis. The patient was admitted on Friday, March 10, 2017 to the hospital's telemetry ward by Dr. L.S.

12. From 8:30 p.m. on March 10, 2017 to 7:00 a.m. on March 11, 2017, the patient's vital signs were noted to be as follows: heart rate ranged from 109 to 125, respiratory rate ranged from 24 to 34, and oxygen saturation ranged from 91 to 100% on supplemental oxygen via a non-rebreather mask. He had a peak temperature of 99°F.

13. On Saturday, March 12, 2017, Respondent, a pulmonologist and critical care specialist, assumed the care of the patient from Dr. L.S. Respondent did not obtain a verbal or written sign out regarding the patient's current condition, planned course of therapy or any specific issues to watch during his shift.

[3] BNP is a hormone produced by the heart and blood vessels. BNP test is a blood test that measures BNP levels. Higher than normal BNP levels are indicative of heart failure.

14. On March 11, 2017 at 9:51 a.m., an EKG report reflected that the patient's EKG performed at 9:19 a.m. revealed sinus tachycardia, possible right ventricular hypertrophy and minimal ST depression.

15. Respondent first saw the patient on the morning of March 11, 2017 at which time he noted that the 32-year old patient presented with shortness of breath for the past 48 hours. Respondent noted that the patient had progressive shortness of breath and dyspnea on exertion. Chest x-ray in the emergency department showed bilateral alveolar infiltrates and he was on a nonrebreather mask. Respondent noted that the patient had a history of diabetes type 2, hypertension, and anemia and that his current medications included Zithromax, Rocephin, Solu-Medrol, Tylenol, Xopenex, Ativan and Robitussin. With respect to his review of systems, Respondent noted that the patient had shortness of breath and chest pain. He had no hypertension or palpitation. With respect to his physical examination, Respondent noted that the patient had bilateral crackles and was tachycardic. The patient's temperature was 97.6°F, heart rate was 115, respiratory rate was 24 and blood pressure was 146/96. With respect to laboratory values, Respondent noted that the patient had a pH of 7.4, CO2 of 30 and oxygen of 55 while on supplemental oxygen. Respondent also noted the patient's sodium of 137, potassium of 5.4, chloride of 98, bicarb of 23, BUN of 28, creatinine of 1.6 and glucose of 426. Respondent did not note the elevated BNP that had been obtained in the emergency department or the EKG findings from the EKG performed earlier that morning.

16. Respondent continued the patient on antibiotics with vacomycin and Zosyn, discontinued the Rocephin and Zithromax and ordered an infectious disease consult. He also ordered a nephrology consult for the patient's reduced renal function. He ordered an HIV test and reduced the IV fluids to 100 cc per hour of normal saline. He ordered a renal ultrasound, cardiac echocardiogram, a lactic acid level, complete blood count, basic metabolic panel and a portable chest x-ray to be performed in the morning on March 12, 2017.

17. Respondent's impression was community-acquired pneumonia with severe hypoxemia. He noted that the patient's condition was guarded and further noted that the patient was aware that "he may require [intensive care unit] transfer if his hypoxemia does not improve."

18. A chest x-ray ordered by Respondent at 12:12 p.m. on March 11, 2017 and performed at approximately 2:56 p.m. on March 11, 2017 revealed rapidly worsening pneumonia and possible pulmonary edema. The radiology report was transcribed at 2:10 p.m. on March 12, 2017 and there is no documentation in the chart reflecting whether or not Respondent reviewed the chest x-ray.

19. The patient and his family wanted the patient to be transferred to PIH Hospital. At 3:00 p.m., Whittier Hospital Case Manager confirmed with Respondent that the patient was stable for transfer as soon as a bed became available at PIH Hospital. At 5:30 p.m., the Whittier Hospital Case Manager noted that the patient was on 15 liters of oxygen with a non-breather mask and not stable to transfer. She further noted that Respondent had been notified that the patient was not able to be transferred "due to high flow oxygen."

20. At 4:03 a.m. on March 12, 2017, the nursing staff noted that the patient's respirations were 47, oxygen saturations were 85% and the patient's sinus rhythm was 128-130. It was further noted that Respondent was paged regarding an update on the patient's respiratory condition.

21. At 4:30 a.m. on March 12, 2017, the nursing staff noted that the patient's respirations were 34, oxygen saturations were 75% and the patient's sinus rhythm was 128-130. It was further noted that Respondent was paged regarding an update on the patient's respiratory condition.

22. At 5:16 a.m. on March 12, 2017, the nursing staff noted that the patient's respirations were 32, oxygen saturations were 87% and the patient's sinus rhythm was 128-130. The patient was noted to be kneeling next to the bed over a chair and stated that it helps him breath better with less pressure on his chest. It was further noted that Respondent was paged regarding an update on the patient's respiratory condition.

23. At 5:26 a.m. on March 12, 2017, the nursing staff noted that internist, Dr. A.M. was paged regarding the patient's respiratory condition and responded. Dr. A.M. stated that he was not the pulmonologist and instructed nursing to continue to page Respondent.

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24. At 5:50 a.m. on March 12, 2017, the nursing staff noted that Respondent was paged regarding the patient's respiratory condition and responded. Respondent ordered that the patient be transferred to the intensive care unit (ICU) and to have the ICU call him for orders to place the patient on BiPAP.[4]

25. At approximately 7:00 a.m., nursing called Respondent to update him on the patient's condition. The patient was in severe respiratory distress and orders for intubation were given. Anesthesiologist, Dr. E.L. was then called to intubate the patient. Dr. E.L. noted that the patient was in respiratory distress and "slumped forward in chair." His saturations were 80%. A blood gas on 100% forced inspiratory oxygen (FIO2) showed a pO2 of 52 and metabolic acidosis (pH 7.33 and PCO2 37.8). Dr. E.L. intubated the patient was a 7.5 mm endotracheal tube and noted that good CO2 return.

26. At 8:50 a.m. on March 12, 2017, the patient was bradycardic and a Code Blue was called. Emergency department physician Dr. S.D. responded. Spontaneous circulation returned following advanced cardiovascular life support interventions. Dr. S.D. noted that Respondent was notified of the Code. A second Code Blue was called at 9:30 a.m. Dr. S.D. again responded. Respondent arrived during the code. Resuscitative efforts were unsuccessful and Respondent pronounced the patient dead at 9:57 a.m.

27. Respondent prepared a death summary at 10:44 a.m. on March 12, 2017 stating that the primary cause of death was "pneumonia." No autopsy was performed.

STANDARD OF CARE

28. The standard of medical practice for a pulmonologist and critical care specialist requires that the physician recognize, intervene and coordinate clinical care when the clinical condition and acuity of the patient changes or worsens. Further, critical care providers must recognize, intervene and coordinate prompt clinical care for life threatening and severe respiratory illnesses, including marked hypoxemia on supplemental oxygen.

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[4] BiPAP (BiLevel Positive Airway Pressure) is a type of ventilator that helps with breathing by supplying pressurized air into the patient's airway.

29. The standard of medical practice for a pulmonologist and critical care specialist requires that the physician perform a complete evaluation of a critically ill patient to determine the nature, extent, and interaction of all the diagnoses, as well as order appropriate diagnostic testing while beginning appropriate presumptive therapies.

30. The standard of medical practice for pulmonologist and critical care specialist requires that the physician assuming the care of critically ill patients to receive verbal or written sign out regarding the patient's current condition, planned course of therapy, and any specific issues to watch on the next shift from the current provider.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence – Failure to Timely Recognize Extremely Ill Patient and Transfer to a Higher Level of Care)

31. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code, in that he engaged in gross negligence by failing to timely recognize that Patient 1 was extremely ill requiring transfer to a higher level of care. Complainant refers to and, by this reference, incorporates herein, paragraphs 8 through 28, above, as though fully set forth herein. The circumstances are as follows:

A. Despite the patient's markedly abnormal vital signs in the twenty-four hours prior to being seen by Respondent on March 11, 2017 and the chest x-ray on March 11, 2017 which revealed worsening bilateral infiltrates from the day before, Respondent failed to timely transfer the patient to an ICU setting for closer monitoring and further diagnostic and therapeutic interventions.

32. Respondent's acts and/or omissions as set forth in paragraphs 8 through 28 and 31(A), above, whether proven individually, jointly, or in any combination thereof, constitute gross negligence pursuant to section 2234, subdivision (b), of the Code. Therefore cause for discipline exists.

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SECOND CAUSE FOR DISCIPLINE

(Gross Negligence – Failure to Timely Form Appropriate Differential Diagnoses in a Critically Ill Patient)

33. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code, in that he engaged in gross negligence by failing to timely form appropriate differential diagnosis for Patient 1, a critically ill patient. Complainant refers to and, by this reference, incorporates herein, paragraphs 8 through 29, above, as though fully set forth herein. The circumstances are as follows:

A. Respondent failed to consider a wide range of possible etiologies for the patient's severe hypoxia, including possible fluid overload, and he continued to give the patient fluids despite the patient being increasingly fluid overloaded.

B. Respondent failed to consider the existing patient care data, including the patient's high BNP level and abnormal chest x-rays, in his assessment of the patient.

34. Respondent's acts and/or omissions as set forth in paragraphs 8 through 29, 31 (A) and 33 (A) and (B), above, whether proven individually, jointly, or in any combination thereof, constitute gross negligence pursuant to section 2234, subdivision (b), of the Code. Therefore cause for discipline exists.

THIRD CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

35. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code, in that he engaged in repeated acts of negligence in the care and treatment of Patient 1. Complainant refers to and, by this reference, incorporates herein, paragraphs 8 through 34, above, as though fully set forth herein. The circumstances are as follows:

A. Despite the patient's markedly abnormal vital signs in the twenty-four hours prior to being seen by Respondent on March 11, 2017 and the chest x-ray on March 11, 2017 which revealed worsening bilateral infiltrates from the day before, Respondent failed to timely transfer the patient an ICU setting for closer monitoring and further diagnostic and therapeutic interventions.

B. Respondent failed to consider a wide range of possible etiologies of the patient's severe hypoxia, including possible fluid overload and he continued to give the patient fluids despite the patient being increasingly fluid overloaded.

C. Respondent failed to consider the existing patient care data, including the patient's high BNP level and abnormal chest x-rays in his assessment of the patient.

D. Despite being paged by the nursing staff from 4:00 a.m. until 5:50 a.m. on March 12, 2017 regarding the changes in the patient's respiratory condition, Respondent delayed in responding to the pages.

E. Respondent failed to obtain a verbal or written sign out regarding the patient's current condition, planned course of therapy and any specific issues to watch when he assumed the care of the patient on March 11, 2017.

36. Respondent's acts and/or omissions as set forth in paragraphs 8 through 34 and 35 (A) through (E), above, whether proven individually, jointly, or in any combination thereof, constitute repeated acts of negligence pursuant to section 2234, subdivision (c), of the Code. Therefore cause for discipline exists.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

37. Respondent is subject to disciplinary action under section 2266 of the Code for failing to maintain adequate and accurate records relating to his care and treatment of Patient 1. Complainant refers to and, by this reference, incorporates herein, paragraphs 8 through 27, above, as though fully set forth herein.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 88276, issued to Richard David Le, M.D.;

2. Revoking, suspending or denying approval of his authority to supervise physician assistants pursuant to section 3527 of the Code, and advanced practice nurses;

3. If placed on probation, ordering him to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED:
November 27, 2018

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

LA2018502573